POSTPARTUM EVALUATION AND POSTPARTUM CONTRACEPTION

I. INTRODUCTION

The postpartum period is defined as the time immediately after delivery extending to approximately 6 weeks postpartum. The majority of women resume sexual activity within several weeks of the delivery. The amount of time following delivery that a woman is infertile is highly variable and dependent on multiple factors, including breastfeeding status. Ovulation can occur even if the mother has not resumed menstruation and can happen as early as 25 days postpartum, underscoring the importance of postpartum contraceptive plan. The probability of ovulation occurring before resumption of menstruation increases over time.

The need to prevent an unplanned pregnancy with a shortened interconception period needs to be balanced with the need to avoid risks of cardiovascular events in women during the postpartum period. Hematologic changes that occur normally during pregnancy result in an increased risk for VTE during the postpartum period. In addition, many postpartum women have additional risk factors that further increase their risk for VTE, such as age ≥35 years, smoking, or recent cesarean delivery. Combined hormonal contraceptives are also associated with an increased risk of VTE among health women of reproductive age. Due to these concerns, recommendations regarding the use of CHC in the postpartum period have changed (see below).

Multiple factors must be considered when making family planning decisions during this time period. These include (1) whether a woman is breastfeeding, (2) the woman's age and smoking status, (3) prior experience(s) with various family planning methods, (4) whether contraception was initiated in the hospital or at a follow-up visit, (5) timing of desired resumption of sexual activity, and (6) general medical history.

II. PLAN OF ACTION

A. Determine whether the client has been seen by her prenatal/intrapartum care provider(s) since delivery.
B. If the client has not been seen, complete the history and physical examination.
    1. Include in the history route of delivery, current contraception usage, breastfeeding status (exclusive vs. supplemented), amount of bleeding, and resumption of sexual activity. Screen for postpartum depression.
    2. Include in the physical, examination of the breasts, surgical incision and/or episiotomy (if any), and Pap test, if indicated (refer to "Cervical Cytology and Management of Abnormal Cytology Results" Clinical Guideline)
C. Answer questions and provide general postpartum counseling
    1. Pelvic rest (no sex, no douching, no tampons) is recommended for 4-6 weeks.
    2. Clients should be strongly advised to abstain from sexual intercourse until postpartum bleeding has stopped.

3. Clients should be encouraged to resume sexual activity only when they feel comfortable and ready.
4. Exercise should be encouraged and can resume gradually. Breastfeeding women should try to breastfeed just prior to exercise to minimize discomfort with engorgement and should try to delay breastfeeding until about an hour after exercise to allow any lactic acid accumulation to dissipate.
5. For breastfeeding women, caloric intake should be 500 kcal higher than usual.
6. For breastfeeding women, calcium intake should be 1200 mg/day.
7. If having breastfeeding difficulties, refer for lactation support/consult.
8. A daily multivitamin is recommended.
9. Women who had gestational diabetes should be screened for diabetes 6-12 weeks postpartum using either a fasting glucose or 2-hour, 75 gram glucose challenge test.
10. Women who were determined to be non-immune to rubella and/or varicella during their prenatal course, should be offered MMR and/or varicella immunization at the postpartum visit.
11. Discuss contraception options (see below) and initiate contraceptive plan as appropriate

III. POSTPARTUM CONTRACEPTION OPTIONS AND CONSIDERATIONS

Choice of contraception method depends on previous history of use, successes or failures, medical contraindications, age, smoking status, and the other usual considerations. Once a choice has been made for an appropriate postpartum method of contraception, the method-specific guideline should be referenced.

A. Combined hormonal contraception (CHC)
   1. Contraindicated in women with peripartum cardiomyopathy (USMEC 3,4)
   2. Non-breastfeeding women:
      a. In women who are <21 days postpartum, use of combined hormonal contraceptives represents an unacceptable health risk and should not be used (USMEC Category 4).
      b. In women who are 21--42 days postpartum and have other risk factors for VTE in addition to being postpartum (smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy), the risks for combined hormonal contraceptives usually outweigh the advantages and therefore combined hormonal contraceptives generally should not be used (USMEC Category 3).
      c. In women who are 21--42 days postpartum and in the absence of other risk factors for VTE, the advantages of combined hormonal contraceptives generally outweigh the risks, and they can usually be used (category 2).
      d. In women who are >42 days postpartum, no restriction applies for the use of combined hormonal contraceptives because of postpartum status (category 1). Nonetheless, any other medical conditions still should be taken into consideration when determining the safety of the contraceptive method.
   3. Breastfeeding women:

a. In women who are <21 days postpartum, use of combined hormonal contraceptives represents an unacceptable health risk and should not be used regardless of breastfeeding status (USMEC Category 4).
b. In breastfeeding women >21 days, but < 1 month postpartum, CHC are associated with decrease in breastfeeding success and other forms of birth control should be first choice (USMEC Category 3).
c. In breastfeeding women >30 days postpartum, without risk factors for VTE (e.g. smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy) and the advantages of CHC outweigh the risks, they can be used, but milk supply may be affected by CHC throughout breastfeeding course (USMEC Category 2).
d. If breastfeeding and ≤42 days postpartum and risk factors for VTE exist (smoking, deep venous thrombosis/pulmonary embolism, known thrombogenic mutations, and peripartum cardiomyopathy), CHC are contraindicated regardless of breastfeeding status (USMEC Category 4)
e. If breastfeeding and >42 days postpartum, CHC may be used but concerns regarding potential impact on milk supply should be discussed (USMEC Category 2). Certain women in particular might be at increased risk for breastfeeding difficulties, such as women with previous breastfeeding difficulties, certain medical conditions, or certain perinatal complications and those who deliver preterm. For these women, as for all women, discussions about contraception for breastfeeding women should include information about risks, benefits, and alternatives. This discussion should include an assessment of risk of unintended pregnancy, which would outweigh potential risks to milk supply related to CHC.

B. Progestin-only methods: Progestin-only hormonal methods, including progestin-only pills (mini-pill), depot medroxyprogesterone acetate injections (DMPA), and implants, are safe for postpartum women, including women who are breastfeeding, and can be initiated immediately postpartum (USMEC Categories 1 and 2). For women who are breastfeeding and are <30 days postpartum progestin-only methods are considered safe (USMEC category 2). Women should be made aware, however, of evidence that in some women, hormonal contraception, including progestin-only methods, may impact supply. Certain women in particular might be at increased risk for breastfeeding difficulties, such as women with previous breastfeeding difficulties, certain medical conditions, or certain perinatal complications and those who deliver preterm. Discussions about contraception for breastfeeding women should include information about risks, benefits, and alternatives. This discussion should include an assessment of risk of unintended pregnancy, which would outweigh potential risks to milk supply related to progestin-only methods.
C. IUCs: IUCs, including the levonorgestrel-releasing IUD and copper-bearing IUD, also can be inserted postpartum, including immediately after delivery (USMEC Categories 1 and 2) and are not associated with an increase in complications. Although IUD expulsion rates are higher when insertion occurs within 28 days of delivery, continuation rates at 6 months are similar among women who receive an IUD postpartum and those who plan for delayed insertion. Despite the higher expulsion rate of immediate postpartum IUD placement over interval placement, evidence from clinical trials and from cost-benefit analyses strongly suggest the

superiority of immediate placement in reduction of unintended pregnancy, especially for those at greatest risk of not having recommended postpartum follow-up. Postpartum sepsis is a contraindication for IUC (USMEC Category 4).

D. Condoms: Condoms can be used anytime (USMEC Category 1)
E. Diaphragm: Diaphragm should be started at 6 weeks postpartum (USMEC Category 1 after 6 weeks).
F. Natural Methods:
    1. Abstinence is the most efficacious form of contraception.
    2. If a woman is breastfeeding regularly (at least every four hours a day and 6 hours at night) without any supplementation or pumping, the Lactational Amenorrhea Method (LAM) can be up to 98% effective as a form of contraception for the first six months postpartum (or until her first period, whichever happens first). However, when feeding supplements are given, a second form of contraception should be used.
    3. Caution clients that it is not possible to practice fertility awareness before their cycles are reestablished, and that the resumption of ovulation (and, therefore, fertility) will precede the first menstruation.
G. Sterilization: Vasectomy or tubal ligation is an appropriate option for couples who desire a permanent contraception option.

IV. FOLLOW-UP

Follow-up timing is dependent on the type of contraception that is initiated.

REFERENCES

1. CDC Medical Eligibility Criteria for Contraceptive Use. MMWR / Vol. 65 / No. 3 / July 29, 2016

2. ACOG. Guidelines for Women's Health Care: A Resource Manual, 4th Edition. 2014.

3. Hatcher RA et al. Contraceptive Technology. 20th Revised Edition. Ardent Media, Inc., New York, 2011.